Patient's Full Name _____ **Parent/ Guardian** _____

Address _____ **Patient's Date of Birth** _____

City, State Zip Code _____ **Telephone Number** _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   Thornburg Pediatrics, LLC
   5500 Bryson Drive, Suite 301
   Naples, FL 34109

   By mail: _____
   By Fax: _____ (239-348-7391)
   (Please fax one patient chart at a time)

The specific information that should be disclosed:

All records_____ Progress notes_____ Labs_____ Consult notes_____ Immunizations_____

Or specific records :_____(please include dates)

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, GENETIC OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, DO NOT DISCLOSE THIS INFORMATION * _____

3. Thornburg Pediatrics, LLC takes all necessary steps to ensure and protect our patient's private health information.
4. I may revoke this authorization by notifying Thornburg Pediatrics in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for: Transfer of care_____ Specialist_____ Personal_____ Other_____.
6. This authorization expires 90 days from signature date.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records.

Members are entitled to one set -free of charge. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.
A photocopy/fax of this authorization will be treated in the same way as an original. Thornburg Pediatrics health records may include records that it received from other organizations. If these records have been used by Thornburg Pediatrics and filed in the record Thornburg Pediatrics maintains about you, these records may be released with your Thornburg Pediatrics records. Thornburg Pediatrics cannot prevent re disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Thornburg Pediatrics from any and all liability resulting from a re disclosure by the recipient. Your signature indicates that you have read and understand this form, and authorize release your information as described above. **Please initial_____**

Signature of Patient/ Parent/ Guardian _____ **Date of Signature** _____ **Date of Birth of patient** _____